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11-30-2004

Proposed Rules
of
The Tennessee Department of Labor and Workforce Development
Division of Workers' Compensation

Medical Cost Containment Program

Presented herein are proposed rules of the Tennessee Department of Labor and Workforce Development submitted pursuant to T.C.A. Section 4-5-202 in lieu of a rulemaking hearing. It is the intent of the Tennessee Department of Labor and Workforce Development to promulgate these rules without a rulemaking hearing unless a petition requesting such hearing is filed within thirty (30) days of the publication date of the issue of the Tennessee Administrative Register in which the proposed rules are published. Such petition to be effective must be filed with the Workers' Compensation Division, Second Floor of the Andrew Johnson Tower located at 710 James Robertson Parkway, Nashville, TN 37243-0661 and in the Department of State, Eighth Floor, Tennessee Tower, William Snodgrass Building, 312 8th Avenue North, Nashville, TN 37243, and must be signed by twenty-five (25) persons who will be affected by the rule, or submitted by a municipality which will be affected by the rules, or an association of twenty-five (25) or more members, or any standing committee of the General Assembly.

For a copy of this proposed rule, contact: E. Blaine Sprouse, Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, Andrew Johnson Tower, Second Floor, 710 James Robertson Parkway, Nashville, TN 37243-0661, (615) 253-0064.

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0800-2-11-.01 Purpose and Scope

- (1) Purpose. Pursuant to Tenn. Code Ann. § 50-6-204 (Repl. 1999 and Public Chapter 962 (2004)), the following rules, together with 0800-2- -01, et seq., the Medical Fee Schedule Rules and 0800-2- .01, et seq., the In-patient Hospital Fee Schedule Rules, are hereby adopted in order to establish a comprehensive medical fee schedule and a related system which includes, but is not limited to, procedures for review of charges, enforcement procedures and appeal hearings, to implement the medical fee schedule. The Commissioner promulgates these medical cost containment rules together with the Medical Fee Schedule and In-patient Hospital Fee Schedule rules to establish the maximum allowable fees for health care services falling within the purview of the Tennessee Workers' Compensation Act. These rules establish the maximum allowable fees. Employers, carriers and providers may negotiate and contract such lesser fees as are agreeable between them, but in no event shall fees charged be in excess of the Medical Fee Schedule and In-patient Hospital Fee Schedule, subject to the listed civil penalties as assessed by the Commissioner.
- (2) Scope. These rules do all of the following:
 - (a) Establish procedures by which the employer shall furnish, or cause to be furnished to an employee who receives a personal injury or suffers an occupational disease arising out of and in the course of employment, reasonable and necessary medical, surgical, and hospital services and medicines, or other attendance or treatment recognized by the laws of the state as legal, when needed. The employer shall also supply to the injured employee dental services, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances necessary to cure, so far as reasonably and necessarily possible, and relieve from the effects of the injury or occupational disease.
 - (b) Establish schedules of maximum fees by a health facility or health care provider for such treatment or attendance, service, device, apparatus, or medicine.
 - (c) Establish procedures by which a health care provider shall be paid the lesser of (1) the provider's usual charge, or (2) the maximum fee established under this rule, or (3) the MCO/PPO or any other negotiated and contracted price, where applicable. In no event shall reimbursement be in excess of the TDWC Medical Fee Schedule. Charges in excess of the TDWC Medical Fee Schedule and the In-patient Hospital Fee Schedule shall, at the Commissioner's discretion, result in civil penalties of \$10,000.00 each assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee. At the Commissioner's discretion, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Tennessee Workers' Compensation Act.
 - (d) Provide for the identification of utilization of health care and health services above the usual range of utilization for such services, based on medically accepted standards, and provide for acquiring by a carrier and by the Division of the necessary records, medical bills, and other information concerning any health care or health service under review.

- (e) Establish a system for the evaluation by a carrier of the appropriateness in terms of both the level of and the quality of health care and health services provided to injured employees, based upon medically accepted standards.
- (f) Authorize carriers to withhold payment from, or recover payment from, health facilities or health care providers which have made excessive charges or which have required unjustified and/or unnecessary treatment, hospitalization, or visits.
- (g) Provide for the review by the Division of the records and medical bills of any health facility or health care provider which has been determined not to be in compliance with this rule or to be requiring unjustified and/or unnecessary treatment, hospitalization or office visits.
- (h) Establish that when a health care facility or health care provider provides health care or health care service that is not usually associated with, is longer in duration than, is more frequent than, or extends over a greater number of days than that health care or service usually does with the diagnosis or condition for which the patient is being treated, the health care provider may be required by the carrier to explain the necessity in writing.
- (i) Provide for the implementation of the Division review and decision responsibility. The rule and definitions are not intended to supersede or modify the workers' compensation laws, the other administrative rules of the Division, or court decisions interpreting the laws or the Division's administrative rules.
- (j) Provide for the certification of carriers determined to be in compliance with the criteria and standards established by this rule in their utilization review of services and charges by health care facilities and health care providers
- (k) Establish maximum fees for depositions/witnesses.
- (l) Establish maximum fees for medical reports.
- (m) Provide for uniformity of billing for provider services.
- (n) Establish the effective date for implementation of these Rules.
- (o) Adopt by reference as part of this rule the Medical Fee Schedule, the In-patient Hospital Fee Schedule and any amendments to that fee schedule.
- (p) Establish procedures for balance billing.
- (q) Establish procedures for reporting of medical claims.
- (r) Establish procedures for obtaining medical services by out-of-state providers.

- (s) Establish procedures for preauthorization of non-emergency hospitalizations, transfers between facilities, and outpatient services expected to exceed \$1000.00 in billed charges for a single date of service by a provider.
- (t) Establish procedures for imposing and collecting civil penalties for violations of the Medical Cost Containment Program Rules, Medical Fee Schedule Rules and In-patient Hospital Schedule Rules.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205, 50-6-233 and Public Chapter 962 (2004).

0800-2-11-.02 Severability and Preemption

If any provision of these Medical Cost Containment Program Rules, the Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules (collectively "Rules") or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rules and the application of the provisions to other persons or circumstances shall not be affected in any respect whatsoever. Whenever a conflict arises between these Rules and any other rule or regulation, these Rules shall prevail.

0800-2-11-.03 Procedure Codes

- (1) Services must be coded with valid procedure or supply codes of the Health Care Financing Administration Common Procedure Coding System (HCPCS). Procedure codes used in these rules were developed and copyrighted by the American Medical Association.
- (2) The most current edition of the Current Procedural Terminology (CPT) should be used for these Guidelines.

0800-2-11-.04 Procedures for Which Codes Are Not Listed

- (1) If a procedure is performed which is not listed in the Medicare Resource Based Relative Value Scale (RBRVS), the health care provider must use an appropriate CPT procedure code. The provider must submit an explanation, such as copies of operative reports, consultation reports, progress notes, office notes or other applicable documentation, or description of equipment or supply (when that is the charge).
- (2) The CPT contains procedure codes for unlisted procedures. These codes should only be used when there is no procedure code which accurately describes the service rendered. A special report is required as these services are reimbursed BR (By Report).
- (3) Reimbursement by the carrier for BR procedures should be based upon the carrier's review of the submitted documentation, the recommendations from the carrier's medical consultant, and the carrier's review of the prevailing charges for similar services as identified by the carrier based on data which is representative of Tennessee charges.

0800-2-11-.05 Modifier Codes

- (1) Modifiers listed in the CPT shall be added to the procedure code when the service or procedure has been altered from the basic procedure described by the descriptor.
- (2) The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed. Reimbursement for modified services or procedures must be based on documentation of reasonableness and necessity and must be determined on a case-by-case basis.
- (3) When Modifier 21, 22, or 25 is used, a report explaining the medical necessity of the situation must be submitted to the carrier. It is not appropriate to use Modifier 21, 22, or 25 for routine billing.

0800-2-11-.06 Total Procedures Billed Separately

Certain diagnostic procedures (neurological testing, radiology and pathology procedures, etc.) may be performed by two separate entities that also bill separately for the professional and technical components. When this occurs, the total reimbursement must not exceed the maximum medical fee schedule allowable for the 5-digit procedure code listed.

- (1) When billing for the professional component only, Modifier 26 must be added to the appropriate 5-digit procedure code.
- (2) When billing for the technical component only, Modifier TC (Technical Component) must be added to the appropriate 5-digit code.

Authority: T.C.A. §§ 50-6-128, 50-6-204, 50-6-205 and Public Chapter 962 (2004).

0800-2-11-.07 Definitions

The following definitions are for the purposes of this chapter only:

- (1) “Act” means Tennessee’s Workers’ Compensation Act, Tenn. Code Ann. §§ 50-6-101, et seq. (1999 Repl. and Public Chapter 962 (2004)).
- (2) “Adjust” means that a carrier or a carrier’s agent reduces a health care provider’s request for payment such as:
 - (a) Applies the Tennessee Workers’ Compensation Division (TWCD) maximum fee;
 - (b) Applies an agreed upon discount to the provider's usual charge;
 - (c) Adjusts to a reasonable amount when the maximum fee is by report;
 - (d) Recodes a procedure;
 - (e) Reduces payment as a result of utilization review.

- (3) “Administrator” means the chief administrative officer of the Workers’ Compensation Division of the Tennessee Department of Labor and Workforce Development.
- (4) “Appropriate care” means health care that is suitable for a particular person, condition, occasion, or place as determined by the Commissioner or the Commissioner’s designee after consultation with the Medical Director.
- (5) “Bill” means a request by a provider submitted to a carrier for payment for health care services provided in connection with a compensable injury, illness or occupational disease.
- (6) “Bill adjustment” means a reduction of a fee on a provider’s bill.
- (7) “BR” (By Report) means that the procedure is not assigned a maximum fee and requires a written description. The description shall be included on the bill or attached to the bill and shall include the following information, as appropriate:
 - (a) Copies of operative reports.
 - (b) Consultation reports.
 - (c) Progress notes.
 - (d) Office notes or other applicable documentation.
 - (e) Description of equipment or supply (when that is the charge).
- (8) “Carrier” means any stock company, mutual company, or reciprocal or inter-insurance exchange or self-insured employer authorized to write or carry on the business of workers’ compensation insurance in this state; whenever required by the context, the term ‘carrier’ shall be deemed to include duly qualified self-insureds or self-insured groups.
- (9) “Case” means a compensable injury, illness or occupational disease identified by the worker’s name and date of injury, illness or occupational disease.
- (10) “Case record” means the complete health care record maintained by the carrier pertaining to a compensable injury, illness or occupational disease and includes the circumstances or reasons for seeking health care; the supporting facts and justification for initial and continual receipt of health care; all bills filed by a health care service provider; and actions of the carrier which relate to the payment of bills filed in connection with a compensable injury, illness or occupational disease.
- (11) “Division” means the Workers’ Compensation Division of the Tennessee Department of Labor and Workforce Development.
- (12) “Commissioner” means the Commissioner of the Tennessee Department of Labor and Workforce Development

- (13) "Complete procedure" means a procedure containing a series of steps which are not to be billed separately.
- (14) "Consultant service" means; in regard to the health care of a covered injury and illness; an examination, evaluation, and opinion rendered by a health care specialist when requested by the authorized treating practitioner or by the employee; and which includes a history, examination, evaluation of treatment, and a written report. If the consulting practitioner assumes responsibility for the continuing care of the patient, subsequent service(s) cease(s) to be a consultant service.
- (15) "Compensable injury, illness or occupational disease" means an injury, illness or occupational disease for which health care treatment is mandated under Tennessee Workers' Compensation Act.
- (16) "Critical care" See most current CPT.
- (17) "Day" means calendar day.
- (18) "Diagnostic procedure" means a service which aids in determining the nature and cause of an occupational disease or injury.
- (19) "Dispute" means a disagreement between a carrier or a carrier's agent and a health care provider on the application of this rule.
- (20) "DRG" (Diagnosis Related Group) means one of the classifications of diagnoses in which patients demonstrate similar resource consumption and length of stay patterns as for Medicare purposes by CMS (see "HCFA").
- (21) "Durable medical equipment" is equipment which (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful to a person in the absence of illness, injury or occupational disease, and (4) is appropriate for use in the home.
- (22) "Established patient" See most current CPT.
- (23) "Expendable medical supply" means a disposable article which is needed in quantity on a daily or monthly basis.
- (24) "Focused review" means the evaluation of a specific health care service or provider to establish patterns of use and dollar expenditures.
- (25) "Follow-up care" means the care which is related to the recovery from a specific procedure and which is considered part of the procedure's maximum allowable payment, but does not include care for complications.
- (26) "Follow-up days" means the days of care following a surgical procedure which are included in the procedure's maximum allowable payment, but does not include care for complications.

- (27) "Follow-up visits" means the number of office visits following a surgical procedure which is included in the procedure's maximum allowable payment, but does not include care for complications.
- (28) "HCFA or CMS" means the Centers for Medicare & Medicaid Services, formerly known as the Health Care Financing Administration of the U.S. Department of Health and Human Services.
- (29) "Health care organization" means a group of practitioners or individuals joined together to provide health care services and includes, but is not limited to, a freestanding surgical outpatient facility, health maintenance organization, an industrial or other clinic, an occupational health care center, a home health agency, a visiting nurse association, a laboratory, a medical supply company, or a community mental health center.
- (30) "Health care review" means the review of a health care case or bill, or both, by a carrier, or the carrier's agent.
- (31) "Health Care Specialist" means a board-certified practitioner, board-eligible practitioner, or a practitioner otherwise considered an expert in a particular field of health care service by virtue of education, training, and experience generally accepted by practitioners in that particular field of health care service.
- (32) "Health Care Specialist service" means, in regard to the health care of a compensable injury, illness or occupational disease, the treatment by a health care specialist, when requested by the treating practitioner, carrier, or by the employee, and includes a history, an examination, evaluation of medical data, treatment, and a written report.
- (33) "Inappropriate health care" means health care that is not suitable for a particular person, condition, occasion, or place as determined by the Commissioner or the Commissioner's designee after consultation with the Medical Director.
- (34) "Incidental surgery" means a surgery performed through the same incision, on the same day, by the same doctor, and not related to the diagnosis.
- (35) "Independent medical examination" means an examination and evaluation conducted by a practitioner different from the practitioner providing care, other than one conducted under the Division's IME Registry Program.
- (36) "Independent procedure" means a procedure which may be carried out by itself, separate and apart from the total service that usually accompanies it.
- (37) "Inpatient services" mean services rendered to a person who is formally admitted to a hospital or whose length of stay exceeds 23 hours.
- (38) "Institutional services" mean all non-physician services rendered within the institution by an agent of the institution.

- (39) “Maximum allowable payment” means the maximum fee for a procedure established by this rule or the provider’s usual and customary charge, whichever is less, except as otherwise might be specified. In no event shall reimbursement be in excess of the TDWC Medical Fee Schedule. Charges in excess of the TDWC Medical Fee Schedule shall, at the Commissioner’s discretion, result in civil penalties of \$10,000.00 each assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee. At the Commissioner’s discretion, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Tennessee Workers’ Compensation Act.
- (40) “Maximum fee” means the maximum allowable fee for a procedure established by this rule, the Medical Fee Schedule and the In-patient Hospital Fee Schedule.
- (41) “Medical admission” means any hospital admission where the primary services rendered are not surgical, psychiatric, or rehabilitative in nature.
- (42) “Medical Director” means the Medical Director of the Division of Workers’ Compensation of the Tennessee Department of Labor and Workforce Development appointed by the Commissioner pursuant to T.C.A. § 50-6-126 (1999 Repl.)
- (43) “Medical only case” means a case which does not involve lost work time.
- (44) “Medically accepted standard” means a measure which is set by a competent authority as the rule for evaluating quantity or quality of health care or health care services and which may be defined in relation to any of the following:
 - (a) Professional performance.
 - (b) Professional credentials.
 - (c) The actual or predicted effects of care.
 - (d) The range of variation from the norm.
- (45) “Medically appropriate care” means health care that is suitable for a particular person, condition, occasion, or place.
- (46) “Medical supply” means either a piece of durable medical equipment or an expendable medical supply.
- (47) “Modifier code” means a 2-digit number used in conjunction with the procedure code to describe unusual circumstances which arise in the treatment of an injured or ill employee.
- (48) “New patient” means a patient who is new to the provider for a particular compensable injury, illness or occupational disease and who needs to have medical and administrative records established.

- (49) “Operative report” means the practitioner's written description of the surgery and includes all of the following:
 - (a) A preoperative diagnosis.
 - (b) A postoperative diagnosis.
 - (c) A step-by-step description of the surgery.
 - (d) An identification of problems which occurred during surgery.
 - (e) The condition of the patient, when leaving the operating room, the practitioner's office, or the health care organization.
- (50) “Ophthalmologist” shall be defined according to Tenn. Code Ann. § 71-4-102(3).
- (51) “Optician” shall mean a licensed dispensing optician as set forth in Tenn. Code Ann. § 63-14-103.
- (52) “Optometrist” means an individual licensed to practice optometry.
- (53) “Optometry” shall be defined according to Tenn. Code Ann. § 63-8-102.
- (54) “Orthotic equipment” means an orthopedic apparatus designed to support, align, prevent, correct deformities, or improve the function of a movable body part.
- (55) “Orthotist” means a person skilled in the construction and application of orthotic equipment.
- (56) “Outpatient service” means a service provided by the following, but not limited to, types of facilities: physicians' offices and clinics, hospital emergency rooms, hospital outpatient facilities, community mental health centers, outpatient psychiatric hospitals, outpatient psychiatric units, and freestanding surgical outpatient facilities.
- (57) “Package” means a surgical procedure that includes but is not limited to all of the following components:
 - (a) The operation itself.
 - (b) Local infiltration.
 - (c) Topical anesthesia when used.
 - (d) The normal, uncomplicated follow-up care/visits. This includes a standard postoperative period of 30 days, except, CPT starred * procedures.

- (58) “Pharmacy” means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.
- (59) “Practitioner” means a person licensed, registered, or certified as an audiologist, doctor of chiropractic, doctor of dental surgery, doctor of medicine, doctor of osteopathy, doctor of podiatry, doctor of optometry, nurse, nurse anesthetist, nurse practitioner, occupational therapist, orthotist, pharmacist, physical therapist, physician's assistant, prosthetist, psychologist, or other person licensed, registered, or certified as a health care professional.
- (60) “Primary procedure” means the therapeutic procedure most closely related to the principle diagnosis.
- (61) “Procedure” means a unit of health service.
- (62) “Procedure code” means a 5-digit numerical sequence or a sequence containing an alpha or alphas and followed by three or four digits, which identifies the service performed and billed.
- (63) “Properly submitted bill” means a request by a provider for payment of health care services submitted to a carrier on the appropriate forms which are completed pursuant to this rule. Properly submitted bills shall include appropriate documentation as required by this rule.
- (64) “Prosthesis” means an artificial substitute for a missing body part.
- (65) “Prosthetist” means a person skilled in the construction and application of prosthesis.
- (66) “Provider” means a facility, health care organization, or a practitioner.
- (67) “Reasonable amount” means a payment based upon the amount generally paid in the state for a particular procedure code using data available from but not limited to the provider, the carrier, or the Tennessee Workers’ Compensation Division.
- (68) “Reject” means that a carrier or a carrier's agent denies payment to a provider or denies a provider's request for reconsideration.
- (69) “Secondary procedure” means a surgical procedure which is performed to ameliorate conditions that are found to exist during the performance of a primary surgery and which is considered an independent procedure that may not be performed as a part of the primary surgery or for the existing condition.
- (70) “Stop-Loss Payment (SLP)” means an independent method of payment for an unusually costly or lengthy stay.
- (71) “Stop-Loss Reimbursement Factor (SLRF)” means a factor established by the Commission to be used as a multiplier to establish a reimbursement amount when total hospital charges have exceeded specific stop-loss thresholds.

- (72) “Stop-Loss Threshold (SLT)” means a threshold of charges established by the Commissioner, beyond which reimbursement is calculated by multiplying the applicable stop-loss reimbursement factor times the total charges identifying that particular threshold.
- (73) “Surgical admission” means any hospital admission where the primary services rendered are not medical, psychiatric or rehabilitative in nature.
- (74) “Tennessee Workers’ Compensation Division (TWCD)” means the Division of Workers’ Compensation of the Tennessee Department of Labor and Workforce Development.
- (75) “Transfer between facilities” means to move or remove a patient from one facility to another for a purpose related to obtaining or continuing medical care. It may or may not involve a change in the admittance status of the patient, i.e., patient transported from one facility to another to obtain specific care, diagnostic testing, or other medical services not available in the facility in which the patient has been admitted. Includes costs related to transportation of patient to obtain medical care.
- (76) “Usual and customary charge” means a particular provider's average charge for a procedure to all payment sources, and includes itemized charges previously billed separately which are included in the package for that procedure as defined by this rule.
- (77) “UB-92, HCFA-1450 or CMS-1450” means the health insurance claim form maintained by HCFA/CMS for use by institutional care providers. Currently this form is known as the UB-92.
- (78) “HCFA-1500 or CMS-1500 (12-90)” means the health insurance claim form maintained by HCFA/CMS for use by health care providers.
- (79) “CDT-3 Codes” means the current dental terminology prescribed by the American Dental Association, including the terminology updates and revision issued in the future by the American Dental Association.
- (80) “American Dental Association, 1999 Version 2000” means the uniform dental claim form approved by the American Dental Association (ADA) for use by dentists, as amended or updated by the American Dental Association.
- (81) “Wage loss case” means a case that involves the payment of wage loss compensation.
- (82) “Workers’ Compensation Standard Per Diem Amount (SPDA),” means a standardized per diem amount established for the reimbursement of hospitals for services rendered.

Authority: T.C.A. §§ 50-6-102, 50-6-204 and Public Chapter 962 (2004).

0800-2-11-.08 Information Program Involving Rules

The Division may institute an ongoing information program regarding this rule for providers, carriers, and employers. The program may include, at a minimum, informational sessions throughout the state, as well as the distribution of appropriate information materials.

0800-2-11-.09 Independent Medical Examination to Evaluate Medical Aspects of Case

- (1) An independent medical examination, other than one conducted under the Division's IME Registry Program, shall include a study of previous history and medical care information, diagnostic studies, diagnostic x-rays, and laboratory studies, as well as an examination and evaluation. This service may be necessary in order to make a judgment regarding the current status of the injured or ill worker, or to determine the need for further health care.
- (2) An independent medical examination, performed to evaluate the medical aspects of a case (other than one conducted under the Division's IME Registry Program), shall be billed using the independent medical examination procedure code 99199 (BR), and shall include the practitioner's time only. The office visit charge is included with the code 99199 and shall not be billed separately.
- (3) Any laboratory procedure, x-ray procedure, and any other test which is needed to establish the worker's ability to return to work shall be identified by the appropriate procedure code established by this rule.

0800-2-11-.10 Payment

- (1) Reimbursement for health care services shall be the lesser of (a) the provider's usual charge, or (b) the maximum fee calculated according to the TWCD Fee Schedule (and/or any amendments to that fee schedule), or (c) the MCO/PPO or any other contracted price, where applicable. A licensed provider shall receive no more than the maximum allowable payment, in accordance with this rule, for appropriate health care services rendered to a person who is entitled to health care service.
- (2) The Medicare RBRVS is adopted by reference as part of this rule. The Medicare RBRVS is distributed by the Office of the Federal Register and is also available on the Internet.
- (3) When extraordinary services resulting from severe head injuries, major burns, and severe neurological injuries or any injury requiring an extended period of intensive care are required, a greater fee may be allowed up to 150% of the fee schedule. Such cases should be billed with modifier 21 or 22 (for CPT coded procedures) and should contain a detailed written description of the extraordinary service rendered and the need therefore.
- (4) Billing for provider services shall be submitted on the forms approved by the Division: UB-92 and HFCA-1500, (or their official replacements).
- (5) A carrier shall not make a payment for a service unless all required review activities pertaining to that service are completed.
- (6) A carrier's payment shall reflect any adjustments in the bill made through the carrier's utilization review program.
 - (a) A carrier must provide an explanation of medical benefits to a health care provider whenever the carrier's reimbursement differs from the amount billed by the provider.

- (b) A provider shall not attempt to collect from the injured employee, employer, or carrier any amounts properly reduced by the carrier pursuant to this rule.
- (7) A carrier shall date stamp medical bills and reports upon receipt and shall pay an undisputed and properly submitted bill within 30 days of receipt. Any carrier that fails to pay an undisputed and properly submitted bill within 30 days of receipt shall be assessed a civil penalty of 1 1/2 % monthly (18% annual percentage rate (APR)). The 1 1/2 % monthly civil penalty (18% APR) shall be compounded monthly.
- (8) When a carrier disputes a bill or portion thereof, the carrier shall pay the undisputed portion of the bill within 30 days of receipt of a properly submitted bill. Any carrier not paying an undisputed portion of the bill within 30 days of receipt shall be assessed a civil penalty of 1 1/2 % monthly (18% APR) on the undisputed portion of the bill. The 1 1/2 % monthly civil penalty (18% APR) shall be compounded monthly.
- (9) Any provider not receiving timely payment of the undisputed portion of the provider's bill may institute a collection action in the court having jurisdiction over such matters to obtain payment of the bill, together with the interest civil penalty of 18% APR. Such providers shall also be entitled to reasonable costs and attorney fees incurred in such collection actions to be paid by the carrier or self-insured employer.
- (10) Billings not submitted on the proper form, as prescribed in these rules and the Medical Fee Schedule rules, may be returned to the provider for correction and resubmission. If a carrier returns such billings, it must do so within 20 days of receipt of the bill. The number of days between the date the carrier returns the billing to the provider and the date the carrier receives the corrected billing, shall not apply toward the 30 days within which the carrier is required to make payment.
- (11) Payments to providers for initial examinations and treatment that are authorized by the carrier or a self-insured employer shall be paid by that carrier or self-insured employer and shall not later be subject to reimbursement by the employee or another medical insurance program, even if the injury or condition for which the employee was sent to the provider is later determined non-compensable under the Act.

0800-2-11-.11 Reimbursement for Employee-Paid Services

Notwithstanding any other provision of this rule, if an employee has personally paid for a health care service and at a later date a carrier is determined to be responsible for the payment, then the employee shall be fully reimbursed by the carrier.

Authority: T.C.A. §§ 50-6-128, 50-6-204, 50-6-205 and Public Chapter 962 (2004).

0800-2-11-.12 Recovery of Payment

- (1) Nothing in this rule shall preclude the recovery of payment for services and bills which may later be found to have been medically paid at an amount which exceeds the maximum allowable payment. This also includes payments reimbursed to an employee pursuant to 0800-2-11-.11 above.

- (2) A carrier may recover a payment to a provider, whether by an employee or a carrier, if the carrier requests the provider for the recovery of the payment, with a statement of reasons for the request, within one year of the date of payment.
- (3) Within 30 days of receipt of the carrier's request for recovery of the payment, the provider shall do either of the following:
 - (a) If in agreement with the request, refund the payment to the carrier.
 - (b) If not in agreement with the request, supply the carrier with a written detailed statement of the reasons for its disagreement, along with a refund of the portion, if any, of the payment that the provider agrees should be refunded.
- (4) If the carrier does not accept the reason for disagreement supplied by the provider, the carrier may file a request for Administrative Review, within 30 days of receipt of the provider's statement of disagreement. The request for review shall be filed with the Medical Director for a determination and the carrier shall supply a copy to the provider.
- (5) If, within 60 days of the carrier's request for recovery of a payment, the carrier does not receive either a full refund of the payment or a statement of disagreement, then, at the option of the carrier, the carrier may do either or both of the following:
 - (a) File a request for Administrative Review as outlined above, of which the carrier shall supply a copy to the provider.
 - (b) Reduce the payable amount on the provider's subsequent bills (in the case in question or any other case) to the extent of the request for recovery of payment.
- (6) If, within 30 days of a final decision of the Medical Director, a provider does not pay in full any refund ordered, the carrier may reduce the payable amount on the provider's subsequent bills to the extent of the request for recovery of payment plus an additional 18%. The carrier may, at its discretion, pursue recovery of such refund in a court of proper jurisdiction pursuant to T.C.A. § 50-6-226.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205, 50-6-226, 50-6-233 and Public Chapter 962 (2004).

0800-2-11-.13 Amounts in Excess of Fees/Penalties for Violations of Fee Schedules

- (1) Providers shall not bill and employers or carriers shall not pay any amount for health care services provided for the treatment of a covered injury or illness or for any other services encompassed within the Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules when that amount exceeds the maximum allowable payment established by those rules. Any provider billing for and any employer or carrier paying an amount in excess of the TDWC Medical Cost Containment Program Rules, Medical Fee Schedule or the In-patient Hospital Fee Schedule shall, at the Commissioner's discretion, be subject to a civil penalties of \$10,000.00 each assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee. At the discretion of the Commissioner, the

Commissioner's Designee, or an agency member appointed by the Commissioner, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Tennessee Workers' Compensation Act. Any other violation of the Medical Cost Containment Program Rules, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules shall subject the alleged violator(s) to a civil penalty of not less than one hundred dollars (\$100.00) nor more than ten thousand dollars (\$10,000.00), at the discretion of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner.

- (2) A provider, employer or insurer assessed a civil penalty for violating the Medical Cost Containment Program Rules, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules has the right to request a contested case hearing to determine if the civil penalty should have been assessed.
- (3) The request for a hearing shall be made in writing by an employer, insurer or provider which has been assessed a civil penalty under these rules.
- (4) Any request for a hearing shall be filed with the Division within fifteen (15) calendar days of the date of the issuance of the civil penalty by the Commissioner. Failure to file a request for a hearing within fifteen (15) calendar days of the date of entry of the issuance of the civil penalty shall result in the decision of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner becoming a final order not subject to further review.
- (5) The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner shall have the authority to hear the matter as a contested case and determine if the civil penalty assessed should have been assessed.
- (6) Upon receipt of a timely filed request for a hearing, the Commissioner shall issue a Notice of Hearing to the employer or insurer.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-233 and Public Chapter 962 (2004).

0800-2-11-.14 Missed Appointment

A provider shall not receive payment for a missed appointment unless the appointment was arranged by the Division, carrier or the employer. If the carrier or employer fails to cancel the appointment not less than one (1) business day prior to the time of the appointment and the provider is unable to arrange for a substitute appointment for that time, the provider may bill the carrier for the missed appointment using procedure code 99199 with a maximum fee of BR.

0800-2-11-.15 Medical Report of Initial Visit and Progress Reports for Other Than Inpatient Hospital Care

- (1) Except for inpatient hospital care, a provider shall furnish the carrier with a narrative medical report for the initial visit, all information pertinent to the compensable injury, illness, or occupational disease if requested at reasonable intervals, and a progress report for every 60 days of continuous treatment for the same compensable injury, illness or occupational disease.
- (2) If the provider continues to treat an injured or ill employee for the same compensable injury, illness or occupational disease at intervals which exceed 60 days, then the provider shall provide a progress report following each treatment that is at intervals exceeding 60 days.
- (3) The narrative medical report of the initial visit and the progress report shall include all of the following information:
 - (a) Subjective complaints and objective findings, including interpretation of diagnostic tests.
 - (b) For the narrative medical report of the initial visit, the history of the injury, and for the progress report(s), significant history since the last submission of a progress report.
 - (c) The diagnosis.
 - (d) As of the date of the narrative medical report or progress report, the projected treatment plan, including the type, frequency, and estimated length of treatment.
 - (e) Physical limitations.
 - (f) Expected work restrictions and length of time if applicable.
- (4) Cost of the narrative medical reports required by 0800-2-11-.15(1) and (2) shall be reimbursed at the following rates: Initial Report-- \$40.00; Subsequent Reports--\$11.00; and Final Report-- \$28.00. Under no circumstances shall a provider bill for more than one report per visit. Initial reports shall billed using procedure code WC101, subsequent reports shall billed using procedure code WC102, and final reports shall billed using procedure code WC103.
- (5) A medical provider shall not charge any fee for completing a medical report form required by the TWCD.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-233 and Public Chapter 962 (2004).

0800-2-11-.16 Additional Reports

Nothing in this rule shall preclude a carrier or an employee from requesting reports from a provider in addition to those specified in the preceding rule.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-233 and Public Chapter 962 (2004).

0800-2-11-.17 Deposition/Witness Fee Limitation

- (1) Any provider who gives a deposition shall be allowed a witness fee.
- (2) Procedure Code 99075 must be used to bill for a deposition.
- (3) Licensed physicians shall be reimbursed for depositions at the rate established in the Division's Rule 0800-2-16-.01

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-233 and Public Chapter 962 (2004).

0800-2-11-.18 Out-of-State Providers

All services and requests for change-of-physician to out-of-state providers must be made to providers who agree to abide by the TWCD Medical Fee Schedule, In-patient Hospital Fee Schedule and Medical Cost Containment Program Rules.

0800-2-11-.19 Preauthorization

Preauthorization is required for all non-emergency hospitalizations, transfers between facilities, and outpatient services expected to exceed \$1000.00 in billed charges for a single date of service by a provider. A denial decision for payment for any type of health care service and/or treatment resulting from a utilization review, as opposed to a determination of whether such service or treatment is related to a compensable injury or occupational disease, shall only be made by an agent of a Utilization Review Company properly approved by the Tennessee Department of Commerce and Insurance as prescribed in the Division's Rule 0800-2-6-.02. Upon emergency admission, notice must be given to the carrier within 24 hours or the next business day.

0800-2-11-.20 Process for Resolving Differences Between Carriers and Providers Regarding Bills

- (1) Carrier's Dispute of a Bill
 - (a) When a carrier adjusts and/or disputes a bill or portion thereof, the carrier shall notify the provider within 30 days of the receipt of the bill of the specific reasons for adjusting and/or disputing the bill or portion thereof, and shall notify the provider of its right to provide additional information and to request reconsideration of the carrier's action.
 - (b) If the provider sends a bill to a carrier and the carrier does not respond in 30 days, and if a provider sends a second bill and receives no response within 60 days from the date the provider supplied the first bill, the provider may then file a request for Administrative Review with the Medical Director of the TDWC, with a copy to the carrier.
 - (c) The carrier shall notify the employer, employee and the provider that the rules prohibit a provider from billing an employee, employer, or carrier for any amount for health care services provided for the treatment of a compensable work-related injury, illness or occupational disease when that amount is disputed by the carrier pursuant to its utilization review program, or when the amount

exceeds the maximum allowable payment established by the Fee Schedules (Medical and In-patient Hospital). The carrier shall request the employee to notify the carrier if the provider so bills the employee, or employer.

(d) The carrier shall notify the Medical Director of the TDWC when a provider attempts to balance bill or attempts to bill when a dispute exists between a carrier and a provider regarding services.

1. A desk audit shall be conducted by the Division on all notices regarding balance billing.
2. The provider and carrier shall be notified of the results of the desk audit.
3. Providers found guilty of balance billing shall be counseled (1st offense) and, at the discretion of the Commissioner, may be subject to civil penalties up to and including a \$10,000.00 civil penalty and may be referred to the appropriate reporting authority and denied the right to participate in providing further services under the Workers' Compensation Act (2nd offense).
4. Providers found guilty of balance billing may ask for a review of the decision before referral by the Medical Director of the TDWC to the appropriate authority.

(2) Provider's Request for Reconsideration of Bill

A provider may request reconsideration of its adjusted and/or disputed bill by a carrier within 30 days of receipt of a notice of an adjusted and/or disputed bill or portion thereof. The provider's request to the carrier for reconsideration of the adjusted and/or disputed bill shall include a statement in detail of the reasons for disagreement with the carrier's adjustment and/or dispute of a bill or portion thereof.

(3) Carrier's Response to Provider's Request for Reconsideration of Bill; Provider's Right to Appeal

- (a) Within 30 days of receipt of a provider's request for reconsideration, the carrier shall notify the provider of the actions taken and a detailed statement of the reasons. The carrier's notification shall include an explanation of the appeal process provided under this rule.
- (b) If a provider is in disagreement with the action taken by the carrier on its request for reconsideration, the provider may file a request for Administrative Review within 30 days from the date of receipt of a carrier's denial of the provider's request for reconsideration, and the provider shall supply a copy to the carrier.

- (c) If within 60 days of the provider's request for reconsideration, the provider does not receive payment for the adjusted and/or disputed bill or portion thereof, or a written detailed statement of the reasons for the actions taken by the carrier, then the provider may make application for Administrative Review.

(4) Disputes

- (a) Unresolved disputes between a carrier and provider due to conflicting interpretation of these Rules and/or the Medical Fee Schedule and In-patient Hospital Fee Schedule may be appealed to, and resolved by, the Medical Director of the TDWC. A request for Administrative Review may be submitted to:

Medical Director of the Workers' Compensation Division,
Tennessee Department of Labor and Workforce Development
710 James Robertson Parkway, Andrew Johnson Tower, 2nd Floor
Nashville, Tennessee 37243.

- (b) Valid requests for Administrative Review do not require a particular form but must be legible and contain copies of the following:
 - 1. Copies of the original and resubmitted bills in dispute which include dates of service, procedure codes, charges for services rendered and any payment received, and an explanation of unusual services or circumstances.
 - 2. Copies of the specific reimbursement.
 - 3. Supporting documentation and correspondence, if any.
 - 4. Specific information regarding contact with the carriers.
 - 5. A verified or declared written medical report signed by the physician.
 - 6. A specific written request for Administrative Review.
- (c) The party requesting Administrative Review must send a copy of the request and all documentation accompanying the request to the opposing party as well.

Authority: T.C.A. §§ 50-6-126, 50-6-204, 50-6-205, 50-6-226, 50-6-233 and Public Chapter 962 (2004).

0800-2-11-.21 Administrative Review of Fee Schedule Disputes/Hearings

(1) Administrative Review Procedure

- (a) When the request for Administrative Review is received by the Medical Director of the TDWC and it is determined that the Division has jurisdiction over the cause of action, all parties shall be notified by certified mail return receipt

requested. All parties shall have thirty (30) days from the date of receipt of notification to submit further evidence, documentation, or clarifications to the Medical Director of the TDWC. After thirty (30) days, a decision will be determined by the Medical Director of the TDWC and an order will be issued to the parties. Prior to this determination, the Medical Director of the TDWC may request all parties to attend a hearing on the matter. The hearing shall be recorded verbatim. Failure to appear at such hearing may result in dismissal of request for Administrative Review.

- (b) Any party feeling aggrieved by the order of the Medical Director of the TDWC shall have ten (10) days from the date of notification to request a rehearing. If no request for rehearing is received within the ten (10) day period, then the order of the Medical Director shall become a final order. A request for rehearing shall be in writing and shall state the grounds upon which the moving party relies. Upon a finding that the record is not complete or that error was made in the hearing process, the Medical Director of the TDWC may order a rehearing. A rehearing shall follow the same procedure as Subsection (1) (a) above.
- (c) Any party aggrieved by the rehearing order or final order of the Medical Director of the TDWC shall have ten (10) days from the date of notification to file a Request for a Contested Case Hearing pursuant to the Uniform Administrative Procedures Act (UAPA), T.C.A. § 4-5-101, et seq., before the Commissioner, the Commissioner's designee or an agency member appointed by the Commissioner. Contested Case Hearings hereunder shall incorporate all of the procedures and rights attendant to contested case hearings pursuant to the UAPA. A Request for a Contested Case Hearing shall be filed with the Tennessee Workers' Compensation Division. The Request shall contain the following:
 - 1. A copy of the Administrative Review Order of the Medical Director from which the party is aggrieved;
 - 2. Copies of all materials submitted to the Medical Director of the TDWC in the Administrative Review proceedings;
 - 3. A statement identifying each portion of the Medical Director's order claimed to be in error; and
 - 4. An explanation of how each portion of the Medical Director's order conflicts with the TDWC Schedule of Medical Fees or this rule.
- (d) The party requesting a contested case hearing shall mail a copy of all materials which are filed to each opposing party. A decision must be entered by the Medical Director before a contested case hearing may be sought.
- (f) If any bill for services rendered under Tenn. Code Ann. § 50-6-204 by a provider of health care is not paid within 30 days after it has been approved by the Division (under either a final order or rehearing order of the Medical Director or pursuant to a contested case hearing) and returned to the responsible party by certified mail return receipt requested, there shall be added to such

unpaid bill an amount equal to one and one half per centum (1 1/2 %) per month or eighteen per centum (18%) annually thereof, which shall be paid at the same time as, but in addition to, such medical bill unless such late payment is excused by the Division.

Authority: T.C.A. §§ 50-6-126, 50-6-204, 50-6-205, 50-6-226, 50-6-233 and Public Chapter 962 (2004).

(2) Computation of Time Periods

In computing a period of time prescribed or allowed by this rule, the day of the act, event or default from which the designated period of time begins to run shall not be included. The last day on which compliance therewith is required shall be included. If the last day within which an act shall be performed or an appeal filed is a Saturday, Sunday, or a legal holiday, the day shall be excluded, and the period shall run until the end of the next day which is not a Saturday, Sunday, or legal holiday. ["Legal holiday" means those days designated as a holiday by the President or Congress of the United States or so designated by the laws of this State.]

(3) Extension of Time; Request; Waiver

A request for an extension of time for the filing of any document shall be filed with the Medical Director of the TDWC in advance of the day on which the document is due to be filed. This requirement may be waived for good cause shown.

0800-2-11-.22 Utilization Review

(1) Scope of this part

Requirements contained in this part shall pertain to utilization review activity as defined by Tenn. Code. Ann. § 50-6-124 with respect to bills (except repriced bills) submitted for payment by a provider for health care or health related services furnished as a result of a compensable injury, illness or occupational disease arising out of and in the course of employment. These rules are intended to supplement and do not in any way displace the Division's Utilization Review Rules, Chapter 0800-2-6.

- (a) A private review agent who approves or denies payment or who recommends approval or denial of payment for hospital or medical services or whose review results in approval or denial of payment for hospital or medical services on a case by case basis, may not conduct utilization review in this state unless such agent is employed by a Utilization Review Company properly approved by the Tennessee Department of Commerce and Insurance as prescribed in the Division's Rule 0800-2-6-.02.
- (b) Merely repricing (matching CPT codes to the fee schedule) patient bills against the Medical Fee Schedule or In-patient Hospital Fee Schedule does not require the private reviewing agent be employed by a Utilization Review Company approved by the Tennessee Department of Commerce and Insurance as prescribed in the Division's Rule 0800-2-6-.02.

- (c) Denying, recommending denial or negotiating inpatient or outpatient bill payment or BR's requires that the Utilization Review Company for which the private reviewing agent is employed is properly approved by the Tennessee Department of Commerce and Insurance as prescribed in the Division's Rule 0800-2-6-.02.

(2) Carrier's Utilization Review Program

- (a) The carrier shall have a utilization review program.
- (b) Utilization review shall be conducted in a reasonable manner and in accordance with this rule.
- (c) Under the utilization review program, the carrier shall do all of the following:
 - 1. Perform ongoing utilization review of medical bills to identify over-utilization of services and improper billing.
 - 2. Determine the accuracy of the procedure coding. If the carrier determines, based upon review of the bill and any related material which describes the procedure performed, that the procedure is incorrectly or incompletely coded, the carrier may recode the procedure, but shall notify the provider of the reasons for the recoding within 30 days of receipt of the bill.
 - 3. Reduce the bill to the maximum allowable payment for that procedure.
 - 4. Refer to the Medical Director of the TDWC all providers whose billing practices indicate over-utilization.
 - 5. A carrier may have another certified entity perform utilization review activities on its behalf.
- (d) The utilization review program, whether operated by the carrier or an entity on behalf of the carrier, shall be certified by the Tennessee Department of Commerce and Insurance as prescribed in the Division's Rule 0800-2-6-.02.
- (e) The carrier shall provide the Division with the name, address, and license number (and a copy of the contract agreement between the carrier and other entity if applicable) of the entity responsible for conducting the carrier's utilization review program.
- (f) The carrier is responsible for notifying the Division when changing reviewing entities.

- (g) For purposes of this rule, a carrier which has another entity perform utilization review activities on its behalf maintains full responsibility for compliance with this rule.
- (h) Under the carrier's utilization review program, the carrier shall make determinations concerning a compensable injury, illness or occupational disease through one of the following approaches:
 - 1. Review by licensed, registered, or certified health care professionals.
 - 2. The application of criteria developed by licensed, registered, or certified health care professionals.
 - 3. A combination of approaches in subdivisions (1) and (2) of this Subsection according to the type of covered injury or illness.
- (i) Licensed, registered, or certified health care professionals shall be involved in determining the carrier's response to a request by a provider for reconsideration of its bill.
- (j) These licensed, registered, or certified health care professionals shall have suitable occupational injury or disease expertise, or both, to render an informed clinical judgment on the medical appropriateness of the services provided.

Authority: T.C.A. § 50-6-124, 50-6-204, 50-6-205, 50-6-233 and Public Chapter 962 (2004).

0800-2-11-.23 Rule Review

The Tennessee Workers' Compensation Division encourages participation in the development of and changes to the Medical Cost Containment Program, the Medical Fee Schedule and the In-patient Hospital Fee Schedule Rules by all groups, associations, and the public. Any such group, association or other party desiring input into or changes made to this rule and associated schedules must make their recommendations, in writing to the Commissioner. After analysis, the Division may incorporate such recommended changes into this rule after appropriate public comment. Schedules shall be reviewed by the Commissioner, in consultation with the Medical Care and Cost Containment Committee and the Advisory Council on Workers' Compensation July 2006 and every year thereafter.

0800-2-11-.24 Provider and Facility Fees for Copies of Medical Records

- (1) Health care providers and facilities are entitled to recover a reasonable amount to cover the cost of copying documents which have been requested by the carrier, self-insured employer, employee, attorneys, and etc.

- (a) Certain procedure code descriptors require the submission of records and/or reports.
- (b) Documentation which is submitted by the provider and/or facility, but was not specifically requested by the carrier, is not allowed a copy charge.
- (2) Health care providers and facilities must furnish an injured employee or the employee's attorney and carriers/self-insureds or their attorneys copies of records and reports upon request. The charge shall be the same as set out in Tenn. Code Ann. § 50-6-204 (Repl. 1999 and Public Chapter 962 (2004)).
- (3) Health care providers and facilities may charge the actual direct cost of copying x-rays, microfilm or other non-paper records.
- (4) The copying charge shall be paid by the party who requests the records.
- (5) An itemized invoice shall accompany the copy.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-233 and Public Chapter 962 (2004).

0800-2-11-.25 Penalties for Violations of Fee Schedules and Medical Cost Containment Program Rules

The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner, shall have the authority to issue civil penalties up to and including \$10,000.00 per violation, as referenced in rule 0800-2-11-.13, for violations of the Medical Fee Schedule, In-patient Hospital Fee Schedule or the Medical Cost Containment Program Rules after notice and an opportunity for a contested case hearing pursuant to the Uniform Administrative Procedures Act, T.C.A. 4-5-101, et seq.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-233 and Public Chapter 962 (2004).